STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152568	A. BUILDING _____ B. WING _____	R 05/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COUNTY DIALYSIS	310 NE 14TH ST WASHINGTON, IN 47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{V 000}	INITIAL COMMENTS This was a revisit for the federal recertification survey completed on 4-16-12. Facility #: 002590 Survey Dates: 5-30-12 Medicaid Vendor #: 200285170A Surveyor: Vicki Harmon, RN, PHNS Census: 46 incenter hemodialysis, 0 home dialysis One Condition for Certification and 16 standard level deficiencies were found corrected during this survey. Daviess County Dialysis was found to be in compliance with the Condition for Certification 42 CFR 494. Quality Review: Joyce Elder, MSN, BSN, RN June 4, 2012	{V 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE